

**RSU NO. 5 SCHOOL DEPARTMENT  
PARENT/MEDICAL PROVIDER REQUEST TO ADMINISTER  
MEDICAL MARIJUANA AT SCHOOL**

Student's Name: \_\_\_\_\_

DOB\*: \_\_\_\_\_ *Note: Medical marijuana can only be administered at school or on a school bus to a student under the age of 18.*

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**A. To be completed by Physician or Certified Nurse Practitioner:**

Reason for use of medical marijuana: \_\_\_\_\_

Form of medical marijuana: \_\_\_\_\_  
*Note: Medical marijuana may only be administered in tincture form.*

Dosage (amount): \_\_\_\_\_

The medical marijuana must be administered during school hours:  Yes  No

If yes, time to be administered: \_\_\_\_\_

Restrictions (including any restrictions on school activities for safety reasons) and/or important side effects:  None anticipated

Yes. Please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

Date prescribed: \_\_\_\_\_

Date to be discontinued: \_\_\_\_\_

Any other necessary instructions or information: \_\_\_\_\_

***NOTE: THE SCHOOL ADMINISTRATOR MAY CONTACT YOU IF THERE ARE FURTHER QUESTIONS CONCERNING THIS REQUEST.***

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

***Note: Any changes to the information above shall require a new request/permission form.***

**B. To be completed by parent/guardian/legal custodian (designated “primary caregiver” under Maine law for medical use of marijuana purposes):**

*I understand and agree that if the school administrator has questions regarding the provider’s order, that the administrator may contact the child’s provider and obtain additional information about the medication. I consent to the provider releasing that information.*

*I have read Board Policy JLCDA-R – Administering Medical Marijuana to Students and understand that I must comply with all the requirements concerning the administration of medical marijuana.*

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

***NOTE: A COPY OF THE CURRENT WRITTEN CERTIFICATION FOR THE USE OF MEDICAL MARIJUANA MUST BE ATTACHED TO THIS FORM.***

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**C. To be completed by school:**

Date received: \_\_\_\_\_ By whom: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Notes: \_\_\_\_\_

Approved: December 14, 2016